DOCUMENT RESUME

ED 432 406 PS 027 820

AUTHOR	Lindeman, Betsy, Ed.
TITLE	Health and Education.
INSTITUTION	Association for Supervision and Curriculum Development, Alexandria, VA.
ISSN	ISSN-1091-2649
PUB DATE	1999-05-00
NOTE	9p.
AVAILABLE FROM	ASCD Service Center, 1703 North Beauregard Street, Alexandria, VA 22311-1714; Tel: 703-578-9600, Tel: 800-933-2723 (Toll-Free); Fax: 703-575-5400 (Stock no. 199255; single-issue copies, $4.50 each. Annual subscription, 4 issues per year, $12.50. Subscription is included in ASCD Premium membership).
PUB TYPE	Collected Works - Serials (022) -- Information Analyses (070)
JOURNAL CIT	ASCD Infobrief; n17 May 1999
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Child Health; *Comprehensive School Health Education; Elementary Secondary Education; Health Education; Health Programs; Health Promotion; *School Health Services; School Responsibility

ABSTRACT

This brief discusses the intersection of health services and education. After introducing the topic of health services within the educational context, the brief discusses coordinated school health programs, defining such programs and offering examples of the programs in practice. The brief then discusses health education and risk behaviors, providing a sidebar on adolescents and risk behaviors. Also discussed are school-based health centers, funding these centers, and integrated service networks. The final two sections of the brief discuss challenges to health in education, namely the balancing of support services with the development of quality education, and the boundaries of schools' responsibilities to students. Contains 30 references. (EV)

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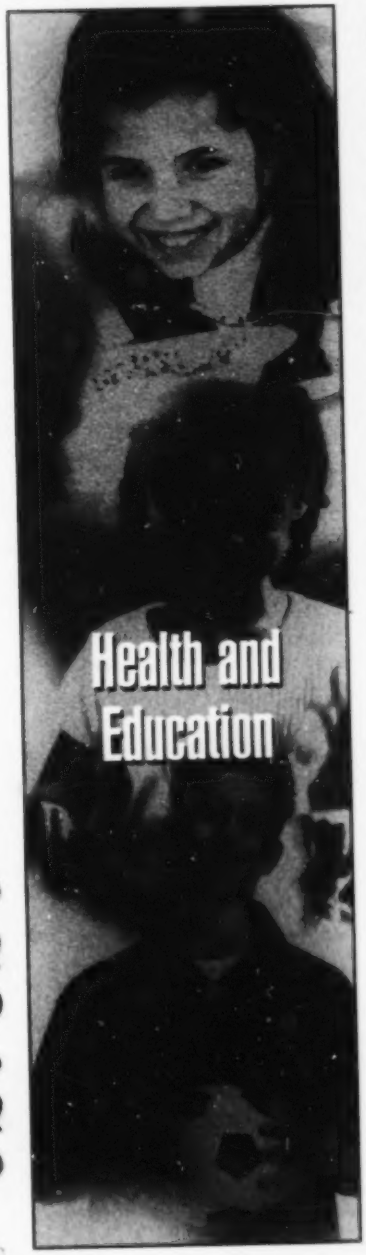
ISSUE 17 · MAY 1999

INFOBRIEF

AN INFORMATION BRIEF OF THE ASSOCIATION FOR SUPERVISION AND CURRICULUM DEVELOPMENT

ED 432 406



A Changing Panorama

By Janis Tomlinson

For many of the baby-boom generation, the mention of health and schools conjures memories of visits to the nurse's office or films shown to junior high school classes, separated by gender for the occasion. In fact, the intersections of health and education in the late 1990s are far more varied and complex than anything that might have been foreseen 30 years ago. Today, coordinated school health programs can encompass multiple components, ranging from classroom instruction to nutrition services to school-based health centers (Marx & Wooley, 1998).

The variations on how individual schools address student and staff needs through such programs attest to a growing awareness that schools are going beyond what many perceive as their traditional role. Few argue with the assumption that good health—physical, emotional, and mental—is a prerequisite for effective learning. As Steinberg (1996) notes, students plagued with health problems or involved with high-risk behaviors such as substance abuse or sexual precocity are less engaged in learning than those who are not.

Integrating health and education increases students' awareness about healthy lifestyles. It also enhances their health and readiness to learn, improves the health of future generations, and reduces costs to society of caring for those whose illnesses might have been prevented through early education and behavior modification. Outcome studies of school-based health services report decreased rates of dropout and teenage pregnancies, fewer hospitalizations, and improved health and higher graduation rates (Dryfoos, 1994; McCord, Klein, Foy, & Fothergill, 1993). Health promotion is also cost-effective: A mathematical prediction of benefits to cost suggests that this ratio for substance abuse education was 5.69, indicating that the value of benefits accrued—or costs of treatment avoided—was almost six times the cost of the program. In comparison, the benefit-to-cost ratio for smoking was 18.86 and for sexual behavior, 5.1 (Rothman et al., 1997).

With such potential benefits, it would seem natural to integrate health with education. But the topic raises myriad questions, among them

- With increasing demands for accountability in more traditional subject areas, should educators take on such a complex issue?
- What are best practices in school health?
- What community partners can be involved in these efforts?
- How will health programs be funded?

In looking at health in education, policymakers must see beyond immediate controversies of course content to consider the proven and potential benefits of programs that promote health among students. These benefits range from enhancing student performance to reducing long-term health care costs. They cannot be reaped, however, without the commitments to provide essential funding and the vision to look beyond traditional boundaries separating health and education.

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Coordinated School Health Programs

Originally defined in a 1987 article, the notion of a comprehensive school health program expands the traditional definition of school health, which had encompassed school health services, education, and the school health environment (Allensworth & Kolbe, 1987). Some proponents, fearing that the term *comprehensive* might suggest an overwhelming task for educators, suggest the term *coordinated school health program* to stress that these initiatives call for a coordination of services that many schools already have in place (Marx & Wooley, 1998). The eight-component coordinated model encompasses comprehensive school health education, physical education, school health services, school nutrition services, school counseling, psychological and social services, health school environment, school-site health promotion for staff and family, and community involvement in school health. According to Allensworth (1995), a school health program can be considered coordinated and comprehensive when it

- Focuses on the key risks to health and learning
- Receives support from students, family, friends, and adults within the school and community
- Draws on the thoughts and efforts of many disciplines, community groups, and agencies
- Uses multiple programs or components
- Provides staff development programs
- Uses inclusive and broadly-based program planning

Coordinated School Health Programs in Practice

The Stow-Munroe Falls City Schools (a suburban Ohio community near Cleveland and Akron) is a coordinated school health program that has, through collaboration of several agencies, overcome the common challenges of lack of administrative support, local obstacles, limited governmental support, and conventional patterns of funding research. Local coordination is achieved through the superintendent's health promotion committee, composed of community, government, and business representatives as well as health care professionals and educators. The committee meets monthly to discuss new concepts for programming. The involvement of local health-related agencies and Kent State University has resulted in minimal costs to local taxpayers; Kent State has also assisted with professional development and curriculum planning, grant writing, and data collection. In a recent interview, Cynthia Symons, professor of health education at Kent State, emphasized that the success of this partnership is grounded in reciprocity: In exchange for its contribution to the Stow-Munroe program, Kent State enjoys access to classrooms for teaching and field work. Kent State, Stow-Monroe, the Ohio Department of Health, and other agencies also collaborate on an annual regional conference that focuses on one of the six risk behaviors defined by the Centers for Disease Control and Prevention (CDC).

The wellness curriculum implemented by the Dallas, Tex., school district illustrates a coordinated school health program in a larger urban community. This program, initiated as a pilot in 1996, integrates four distinct but related curriculum programs or initiatives: character education, health education, physical education, and the guidance curriculum. Fully supported by the Dallas school board, the program is guided by representatives from each department who serve on a steering committee that meets monthly. For a school to adopt the program, at least 80 percent of its faculty and staff must agree to its implementation; the school is then monitored by a team that visits at least twice a year to ensure that all aspects of the program are implemented and standards are met. To help school staff know how to direct the program to meet student needs, each school is given contextual data in early summer, before the annual development of a campus improvement plan. That data goes beyond test scores to list the number of pregnant students, the number of students referred to special education, the suicide rate, and the school's specific youth risk behavior statistics as defined by the CDC. According to Linda Perez Yater, assistant superintendent for student wellness and responsibility, similar data will be used to assess the effectiveness of these programs, currently adopted by 125 of the 216 schools within the Dallas school district. Through evening meetings, parents also have the opportunity to learn about the program; a recent meeting of middle school parents, conducted in Spanish, had record attendance.

As these two programs illustrate, coordinated health programming requires the buy-in of school and district leaders: School-level support and leadership are essential to successful implementation, and school board policy is needed for long-term survival (Marx & Wooley, 1998). To avoid redundancy of efforts, some states are assuming a larger role in the development of these programs. In 1990, the governor of West Virginia developed a task force on school health that included educators, health professionals, and representatives of the business community. Five years later, 85 percent of the recommendations of the original task force had been addressed at least partially. In 1997, a new task force was formed that replicated the four teams of the 1990 group (education, policy and environment, financing and resources, and services) and created a

strategic plan whose implementation is currently monitored by an ongoing state school health committee.

Health Education and Risk Behaviors

In 1988, the CDC established the Division of Adolescent and School Health (DASH) within the National Center for Chronic Disease Prevention and Health Promotion. The mission of DASH is to "identify the highest priority health risks among youth, monitor the incidence and prevalence of those risks, implement national programs to prevent risks, and evaluate and improve those programs" (CDC, 1999). The Youth Risk Behavior Surveillance System (YRBSS) was established to monitor the prevalence and incidence among youth of behaviors that increase mortality, morbidity, and social problems. Unintentional and intentional injuries, alcohol and other drug use, and sexual behaviors have the greatest direct effect on the mortality and morbidity of youth ages 5–24. Other risk behaviors—tobacco use, dietary patterns, and physical inactivity—are based on lifestyle choices often made during adolescence. These behaviors have a long-term effect and account for nearly two-thirds of adult mortality: heart disease (34 percent), cancer (25 percent), and strokes (7 percent) (CDC, 1997).

The use of these risk behaviors as a framework for health curriculums marks a departure from the previously defined health education content areas of community health, consumer health, environmental health, family life, mental and emotional health, injury prevention and safety, nutrition, personal health, prevention and control of disease, and substance use and abuse. Content areas and risk behaviors are addressed by the National Health Education Standards, developed from 1992 to 1995 by a joint committee with funding from the American Cancer Society. The desired outcome is to ensure that students are health literate—that is, that they have the capacity to "obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which enhance health" (Joint Committee on National Health Education Standards, 1995, p. 5). The standards are intended as a framework to be adapted to the needs of the community.

The flexibility of the Health Education Standards seems appropriate given the ongoing discussions on the most effective ways to teach health issues. A growing interest on behalf of health educators in problem behavior theory illustrates current innovation in the field. Recognizing that risk behaviors are often "clustered"—that is, a teenager who abuses drugs or alcohol will be at greater risk for unintentional injury and possibly also from sexual behavior—this approach recommends addressing the predisposing causes that lead to the risk behavior. However, one obstacle to such an approach is that "most school systems do not conceptualize health education from this perspective. Indeed, health instruction is broken down into discrete content areas, more akin to the risk-factor-specific approach" (Carnegie Corporation, 1995).

School-Based Health Centers

In 1988, there were fewer than 100 school-based health centers in the United States; by 1998, there were 1,157 (Making the Grade, 1999). Of these, 63 percent were urban, 25 percent were rural, and 11 percent were suburban. Thirty-seven percent were based in high schools, 34 percent in elementary schools, and 16 percent in middle schools; 57 percent operated full time, with a primary care provider on-site 25 hours or more per week.

School-based health centers (SBHCs) combine medical care with preventive and mental health services on the school campus, extending school health services to serve specific needs of children in the community. In addition to traditionally available services such as first aid, the SBHC might offer physical examinations, treatments for minor injuries and illnesses, screening

ADOLESCENTS AND RISK BEHAVIORS

Statistics suggest that more adolescents are engaged in high-risk behaviors than ever before. Since 1992, there has been a steady increase in the number of 12th graders who reported smoking cigarettes daily or using illicit drugs within the preceding 30 days and of those who reported having five or more drinks in a row in the past two weeks (Federal Agency Forum on Child and Family Statistics, 1998). School property is in no way sacrosanct, providing a site for at least some of this activity: During the 30-day period preceding a 1997 survey, almost 15 percent of students had smoked cigarettes, 5 percent had used smokeless tobacco, and 7 percent had used marijuana on school property (CDC, 1999). In the short term, these behaviors create academic, health, and disciplinary problems in schools. In the long term they may lead to even greater consequences: In the United States today, lifestyle choices—often made during adolescence—are the cause of 50 percent of premature deaths, a number far greater than those caused by inherited and genetic factors (20 percent), environmental factors (20 percent), or the inadequacies of the health care system (10 percent) (McGinnis & Foege, 1993).

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for sexually transmitted diseases, pregnancy tests, and psychosocial services (Dryfoos, 1997). Staffing varies but can include a variety of health professionals, including nurse practitioners, social workers, and doctors from the community. The potential benefits of the SBHC model were summarized by a team that assessed use by students already enrolled in managed care plans (Kaplan, Calonge, Guernsey, & Hanrahan, 1998). The benefits they cited include

- Reduced physical barriers to access for students who might not have transportation to a center off school grounds
- Improved compliance and follow-up
- Accessibility of self-initiated confidential care
- Emphasis on early identification of high-risk problems
- Provision of services customized for the adolescent population
- Integration of health promotion in the school environment
- Reduction of health care costs by using midlevel practitioners to provide services

Funding School-Based Health Centers

In 1994, Congress established the first federal program to fund the creation of SBHCs, the Healthy Schools/Healthy Communities Program (administered by the Bureau of Primary Health Care of the U.S. Department of Health and Human Services). In 1998, the program designated $8 million for grants to fund on-site primary health care services. State governments provide substantial funding to these centers through allocations of the Social Security Title V Maternal and Child Health Care block grant funds (MCHBG) and other general funds. From 1997–1998, states contributed $29 million in general funds, an increase of $2 million since 1996; during this same period, MCHBG funds fell by more than $3.5 million to $9.27 million. Other sources of funding include almost $9 million in Medicaid payments (Making the Grade, 1999). The recent federal initiative to expand health insurance coverage to millions of uninsured children, the Child Health Insurance Program, is another potential source of funding, as are monies from the recent legal settlement of 46 states with the tobacco industry. Private foundations continue to provide an important source of revenue.

In a recent interview, Julia Graham Lear, director of Making the Grade, a resource center at George Washington University for SBHCs, stressed that local buy-in and financial support are essential to the success of the SBHCs. "When you are trying to serve a population—such as all school-age children—within a community, hard money is essential. Systems functions must be system funded." In Seattle/King County (Wash.), 100 percent of the support for the SBHC comes from local sources. In 1988, the city of Seattle provided funding to the Seattle/King County Department of Public Health for a three-year pilot program to create an SBHC in a local high school. When a newly elected mayor held a citywide summit with students, parents, educators, health care providers, and social services agencies to determine how the city and school district could work together to strengthen public education, the center was a major beneficiary. A package of programs was developed, funded by a property tax enacted in November 1990. During the next seven years, $69 million was raised to support the public education package, including SBHCs. A second levy, passed in November 1997, will provide funding until 2004. As of spring 1998, eight of the city's ten high schools had SBHCs; three more were to open the following year. More long-term plans include opening SBHCs in as many as five middle schools and another high school. According to Anne T. Curtis, manager of school-age health for the health department, a work group is now being formed to examine long-term support for the centers. "The second levy passed easily this time, and I imagine it will next time as well, but you never know. It's hard to predict what the political climate will be in the future, so we've got to be prepared" (Making the Grade, 1998).

Integrated Service Networks

As part of its health program, a school might also participate in an integrated service network. Although human services organizations have been involved in services integration for more than a quarter of a century, it wasn't until the 1980s that there was a call for schools to become more involved in programs that brought together a variety of services used by low-income families. One example of state coordination of this effort is Missouri's Caring Communities Program, launched in 1989 with the support of the Danforth Foundation and the coordination of the state departments of Elementary and Secondary Education, Mental Health, and Health and Social Services. The Walbridge Elementary School in St. Louis was a pilot site for

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(ISSN 1091-2649)

this program, offering before- and after-school programs, intensive services for troubled families, case management, substance abuse counseling for families, day treatment for emotionally disturbed children, and health services. According to a 1993 report of the U.S. General Accounting Office, the Walbridge program produced a 26 percent improvement in academic achievement. Today there are more than 60 Caring Communities in urban and rural sites throughout Missouri (Caring Communities, 1999).

Challenges to Health in Education: Beyond Funding

The introduction of a broader range of services within the schools also provides new challenges. The most general of these is to balance the introduction of support services with the development of quality education (Dryfoos, 1994). A 1992 Center for the Future of Children study of school-linked services, cited by Emihovich and Herrington (1997), outlines issues faced by educators as they brought more services into the school, including

- Coordinating school programs with other community professionals and working with other professionals and the services they provide on the school site
- Addressing concerns of parents and others community members in expanding the availability of health services to students
- Deciding how to justify assuming responsibilities for health when many schools are perceived to be falling short of their primary educational mission

Controversy often accompanies the start-up of many SBHCs, as community members and parents express their concerns about the center possibly preempting parents in overseeing medical care and counseling of their children, or the center's provision of birth control services. Two effective strategies for deflecting such opposition are to include parents in planning and advocacy efforts and to establish a communitywide advisory committee for the center (Marks & Marzke, 1993). Darlene Young, school-based health center program manager for the health department of Multnomah Country, Oreg., reports that they had to address parental concerns about SBHCs through community meetings before they could open the first center in Portland (Making the Grade, 1998a).

Public opinion about SBHCs has nevertheless undergone a major shift since 1986, when Florida's governor turned down a grant to fund a center in Miami's Northwestern High School. The grant was accepted by the Dade County Public Health Trust, and today that center serves 2,500 of the 3,000 students in the school and is one of 10 SBHCs in Miami (Making the Grade, 1998b). It should also be stressed that all SBHCs have some form of parental consent process, allowing parents to choose the services that their children may access (Dryfoos, 1994; Emihovich & Herrington, 1997).

Parents are also often concerned about the content of courses involving what is popularly called *sex education* but also known as *family life education* or *sexuality education*. This concern frequently eclipses other issues, to the extent that health education is often understood as a euphemism for sexual education. However, results of a recent survey suggest that attitudes toward the subject change when more is learned about the actual content of such courses. The 62-question survey examined attitudes toward sexuality education among registered voters in South Carolina. Although only 63 percent of the respondents supported sexuality education at the outset of the questioning, 81 percent supported it when asked a second time at the conclusion of the survey. This shift may well be attributed to the fact that respondents learned as they took the survey that sexuality education entailed far more than such contentious issues as "safer sex" versus "abstinence" (Lindley et al., 1998).

The focus on safer sex versus abstinence was sharpened in 1996, when Congress appropriated $50 million annually for

SUPPORT FOR HEALTH EDUCATION

A 1997–1998 survey of attitudes toward current academic standards (Marzano, Kendall, & Cicchinelli, 1998) showed that almost three quarters (74 percent) of U.S. adults older than 18 consider learning about health "definitely" important. That students should "understand aspects of substance use and abuse" was ranked the highest by respondents among all set standards in all disciplines (90 percent); it was followed by "uses grammatical and mechanical conventions in written compositions" (83 percent); "understands the relationship of family health to individual health" (80 percent); "knows essential concepts about the prevention and control of disease" (79 percent); "knows the characteristics and uses of computer software programs" (76 percent); and "knows how to maintain mental and emotional health" (76 percent). These findings corroborate those of a 1994 American Cancer Society survey in which four out of five parents endorsed comprehensive school health education as more or equally important as other subjects taught (Institute of Medicine, 1997).

five years for states that taught "abstinence only" until marriage. Supported programs cannot discuss birth control or prevention of sexually transmitted diseases. This funding posed a major dilemma for educators and health officials, who ran the risk of offending birth control groups with whom they had worked for years if they applied—or passing up an important opportunity to help children if they did not (Mathews, 1997). The approach taken in New Jersey illustrates one solution: The annual payment of $800,000 would not be used in the public schools, where the approved state curriculum included lessons on abstinence as well as contraception. Instead, the funds went to health departments and nonprofit groups to teach 10- to 14-year-old students to refrain from sex, drugs and alcohol, and the "skills needed to reject sexual advances," according to New Jersey Governor Christine Todd Whitman (Goodnough, 1998).

Although it does not often make newspaper headlines, educators' preparedness to teach health effectively is of great concern to health education advocates. A snapshot of health education in the United States was offered by the 1994 CDC-sponsored School Health Policies and Programs Study (SHPPS). Although 77.6 percent of the lead health education teachers had taught or coordinated health education for at least five years, less than 5 percent (4.4 percent) had majored in health education; about one quarter (27.2 percent) majored in physical education; about 22 percent majored in health and physical education; about 13 percent majored in biology; and almost 37 percent majored in a non-health-related field. Increasing the number of health education teachers who major in health education is, according to the authors of the report, essential to strengthening school health education in the future (Collins et al., 1995, p. 307).

A recent survey of teachers in Montana's health enhancement program—a program that combines physical education with health education—attests to the lack of preparedness that teachers themselves feel in dealing with health issues. Teachers were asked how equipped they felt to teach each of several areas required by state standards and how important they felt these issues to be. Across the board, teachers felt better prepared to teach subjects traditionally identified with physical education such as team sports or fundamental motor skills; they felt far less ready to teach topics traditionally aligned with health education such as disease prevention or conflict resolution. Based on their findings, the authors noted the dangers of unifying physical education and health education under such rubrics as "wellness" or "health promotion," rubrics that risk relegating health education to second-class status (Sondag & Burns, 1998).

WHERE ASCD STANDS

ASCD has adopted the following positions that support health in education:

Community Support Services: Especially in neighborhoods with high levels of poverty, public schools should collaborate with community agencies to make support services such as child care, health, and dental services available to students and their families.

Health Education: Schools should offer comprehensive health education programs including instruction about the human body, nutrition, and AIDS prevention, and prevention of substance abuse.

In addition, schools should provide positive lifestyle models by serving nutritious school lunches, providing appropriate physical education programs, maintaining safe environments, and offering students the emotional support necessary to reduce stress and prevent substance abuse. Prevention education is best carried out in partnership with parents, the community, and state and national agencies.

Schools' Responsibilities: Public schools in the United States are expected, and frequently required, to deal with numerous societal problems, including substance abuse, infant mortality, crime, disease, and poverty. Serious societal problems do severely limit the ability of schools to perform their primary function, but most schools are ill prepared to meet these demands. If schools are to assume such responsibilities, including collaboration with other community agencies, they must have adequate funding and other resources.

Sexuality Education: Family life and sexuality education is the responsibility of families, religious institutions, and schools. School programs should be developed in cooperation with community groups, including family members, representatives of the health professions, educators, and students.

Social and Emotional Learning: Schools should collaborate with parents and community agencies to foster students' social and emotional health.

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Whose Responsibility?

The concept of extended services raises the difficult question of where the school's responsibilities end. The boundaries are sometimes difficult to determine. The committee that issued the 1997 Institute of Medicine report *Schools and Health* endorses the 1994 statement of the Committee For Economic Development:

> Schools are not social service institutions; they should not be asked to solve all our nation's social ills and cultural conflicts. States and communities must lift the burden of addressing children's health and social needs from the backs of educators. They must, of course, arrange needed school services for children and their families, often in collaboration with the schools. But other state and community agencies should pay for and provide these services so that schools can concentrate on their primary missions: learning and academic achievement. (Institute of Medicine, 1997, p. 181)

Increasing accountability for student outcomes might well encourage educators to confront health-related issues that keep students from reaching their potential, according to Catherine Emihovich and Carolyn D. Herrington (1997). They write,

> Toleration that once may have existed for the lower performance by certain groups—such as minority, poor, or handicapped students—or for some students dropping out before completing high school is disappearing. And because the research is unambiguous that poor health impairs learning . . . educators are more inclined to support the early identification of health problems that may impair learning and more aggressive efforts to address them. (p. 9)

As school health expands beyond the school to encompass the community, its intersection with public health seems inevitable. Alfred Sommer, dean of the School of Public Health at Johns Hopkins University, suggests that the words *public health* be expunged: "They carry too much baggage: washing your hands, flushing the toilet, poor doctors for poor patients." He instead recommends speaking of a "complex, diverse, integrated and dynamic enterprise composed of many disciplines, whose goal is protecting and improving the 'health of the public.' . . . Public health is a 'goal' achieved through multidisciplinary teams composed of numerous professions" (Sommer, 1995, p. 110). Current trends in school health programs follow a similar trajectory and confront a need to replace outdated images of health in schools with far more dynamic and interdisciplinary models that respond to the needs of students and involve multiple resources within and outside of the school building. The objective of these programs goes beyond health literacy or the availability of birth control to the creation of a healthier student population that is ready to learn and prepared to make health-literate choices. The ultimate goal is the increased health of the population as a whole.

ASCD HEALTH IN EDUCATION INITIATIVE

Health care professionals and educators interested in health issues share a growing interest in developing health literacy to promote healthful lifestyles. This convergence of interests opens the door to new collaborations. The ASCD Health in Education Initiative, made possible through the generous support of the Robert Wood Johnson Foundation, is intended to encourage such initiatives and to foster student awareness of public health issues, methods, and careers. As part of the initiative, 10 grants will be awarded to junior, middle, and high schools that partner with a community-based public health organization to bring these issues into the curriculum in an innovative fashion.
For more information, see <http://www.ascd.org/health_in_education>.

References

Allensworth, D. (1995). *The comprehensive school health program: Essential elements.* Unpublished manuscript.

Allensworth, D. D., & Kolbe, L. J. (1987). The comprehensive school health program: Exploring an expanded concept. *Journal of School Health, 57*(10), 410.

Caring Communities Network. (1999). *Caring communities: A better way* [Online]. Available: <http://www.modmh.state.mo.us/homeinfo/progs/caring/better.html>.

Carnegie Corporation. (1995). *Great transitions: Preparing adolescents for a new century* [Online]. Available: <http://www.carnegie.org/reports/great_transitions/gr_exec.html>.

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health. (1999). Division of Adolescent and School Health Web site [Online]. Available: <http://www.cdc.gov/nccdphp/dash/what.htm>.

Centers for Disease Control and Prevention, Division of Adolescent and Student Health (1997). *1997 Youth risk behavior surveillance system* [Online]. Available: <http://www.cdc.gov/nccdphp/dash/yrbs/natsum97/suschprop97.html>.

Collins, J. L., Leavy Small, M., Kann, L., Collins Pateman, B., Gold, R. S., & Kolbe, L. J. (1995, October). School health education. *Journal of School Health, 65*(8), 307–312.

Committee for Economic Development, Research and Policy Committee. (Ed.). (1994). *Putting learning first: Governing and managing the schools for high achievement.* Washington, DC: Author.

Dryfoos, J. D. (1994). *Full service schools: A revolution in health and social services for children, youth, and families.* San Francisco: Jossey-Bass.

Dryfoos, J. D. (1997). New approaches to the organization of health and social services in schools. Appendix D in Institute of Medicine *Schools and health: Our nation's investment* (pp. 365–415). Washington, DC: National Academy Press.

Emihovich, C., & Herrington, C. D. (1997). *Sex, kids and politics: Health services in schools.* New York: Teachers College Press.

Federal Agency Forum on Child and Family Statistics. (1998). *America's children: Key national indicators of well-being.* Washington, DC: U.S. Government Printing Office.

Goodnough, A. (1998, January 27). Sex education classes will get federal aid. *New York Times*, p. B7.

Institute of Medicine. (1997). *Schools and health: Our nation's investment.* Washington, DC: National Academy Press.

Joint Committee on National Health Education Standards. (1995). *National health education standards: Achieving health literacy.* (Available from the American Cancer Society, Telephone 800-227-2345)

Kaplan, D. W., Calonge, B. N., Guernsey, B. P., & Hanrahan, M. B. (1998, January). Managed care and school-based health centers: Use of health services. *Archives of Pediatrics and Adolescent Medicine, 152*, 25–33.

Lindley, L. L., Reininger, B. M., Vincent, M. L., Richter, D. L., Saunders, R. P., & Shut, L. (1998, May). Support for school-based sexuality education among South Carolina voters. *Journal of School Health, 68*(5), 205–212.

Making the Grade. (1998a, Winter). Exploring the evolution of school-based health centers. *Access* [Online]. Available: <http://www.gwu.edu/~mtg/pub/access/Winter98.html>.

Making the Grade. (1998b, Spring). Local funding for SBHCs: How did they do that? *Access* [Online]. Available: <http://www.gwu.edu/~mtg/pub/access/Spring98.html>.

Making the Grade. (1999). *National survey of state school-based health centers initiatives: School year 1997–98.* [Online]. Available: <http://www.gwu.edu/~mtg/sbhc/98summ.html>.

Marks, E. L., & Marzke, C. H. (1993). *Health caring: A process evaluation of the Robert Wood Johnson Foundation's school-based adolescent health care program.* Princeton, NJ: Mathtech.

Marx, E., Wooley, S. F., & Northrup, D. (1998). *Health is academic: A guide to coordinated school health programs.* New York: Teachers College Press.

Marzano, R. J., Kendall J. S., & Cicchinelli, L. F. (1998). *What Americans believe students should know: A survey of U.S. adults* [Online]. Available: <http://www.mcrel.org/survey>.

Mathews, J. (1997, July 8). Sex-ed funds worry states: Lessons on teen abstinence stir debate. *The Washington Post*, p. A1.

McCord, M., Klein, J., Foy, J., & Fothergill, K. (1993). School-based clinic use and school performance. *Journal of Adolescent Health, 14*(2), 91–98.

McGinnis, J. M., & Foege, W. H. (1993). Actual causes of death in the United States. *Journal of the American Medical Association, 270*, 2207–2212.

Rothman, M. L., Ehreth, J. L., Palmer, C. S., Collins, J., Reblando, J. A., & Luce, B. R. (1993). *The potential benefits and costs of a comprehensive school health education program.* Paper presented at the annual meeting of the American Public Health Association, San Francisco, CA.

Sommer, A. (1995, November/December). Whither public health? *Public Health Reports, 10*, 659.

Sondag, K. A., & Burns, C. E. (1998, November/December). Integrating health and physical education: A data-based assessment of theory versus practice. *Journal of Health Education, 29*(6), 359–364.

Steinberg, L. (1996). *Beyond the classroom: Why school reform has failed and what parents need to do.* New York: Simon and Schuster.

Resources

American Alliance for Health, Physical Education, Recreation and Dance
http://www.aahperd.org

American School Health Association
http://www.ashaweb.org

Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health
http://www.cdc.gov/nccdphp/dash/

Health is Academic
http://www.edc.org/HealthIsAcademic

Making the Grade
http://www.gwu.edu/~mtg

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